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Pig of a job

Pharmacies swamped as swine flu workload escalates page 6

PLUS

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Canesten Hydrocortisone contains a hard-working combination of active ingredients which provide rapid relief not only from inflamed athlete's foot but from sweat rash too.

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...information for Canesten® Hydrocortisone
...tion: ***Canesten® Hydrocortisone*** contains ...hydrocortisone 1% w/w. **Indications:** ...intertrigo where co-existing ...inflammation require rapid relief. **Dosage and ...:** Apply thinly and evenly twice daily and rub in ...the treatment of seven days. **Contra-...ations:** Use in the eyes, mouth or mucous ...branes, broken or large areas of skin, cold sores or ...for treatment periods longer than seven days, hypersensitivity to ingredients. Only if prescribed by doctor: children under 10 years; pregnancy and lactation; on ano-genital area; to treat ringworm or secondarily infected skin conditions. For hydrocortisone component: any untreated bacterial skin diseases, chicken pox, vaccination reactions, perioral dermatitis, viral skin diseases (e.g. herpes simplex, rosacea, shingles). **Warnings and Precautions:** This product contains cetostearyl alcohol, which may cause local skin reactions (e.g. contact dermatitis). Long-term continuous therapy to extensive areas of skin should be avoided. Avoid covering treated area with tight dressing. **Side-effects:** Rarely local mild burning or irritation immediately after use. Hypersensitivity reactions may occur. After use on large areas and/or after long-term use or use under occlusive dressings, skin atrophy, teleangiectasis, hypertrichosis, striations, hypopigmentation, secondary infection and acneiform symptoms may occur. **Use in pregnancy:** Only when considered necessary by a physician. **RRP:** £5.33. **MA Number:** PL 00010/0216. **MA Holder:** Bayer plc, Consumer Care Division, Newbury, Berkshire RG14 1JA. **Legal Category:** P. **Date of Preparation:** January 2008.

...Date of preparation: March 2009

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PPA ABC

> ‘FEARS THAT ORGANISED CRIME MAY TARGET ANTIVIRAL COLLECTION POINTS ADDS ANOTHER VENEER TO THE SURREAL SCENARIO’

England’s chief medical officer Sir Liam Donaldson warned this week that the NHS faces its biggest challenge in 40 years in dealing with the rapid increase in swine flu cases.

It seems like only yesterday that we watched the first TV reports about swine flu in Mexico. But in the blink of an eye it has spread across the globe and there have now been at least 700 deaths attributed to the H1N1 virus since it emerged in April.

At home, health professionals working on the frontline of patient care are already struggling with rapidly rising workloads caused by the pandemic.

And with the health secretary predicting 100,000 new swine flu cases every day by the end of next month, the UK’s community pharmacy network will be severely stretched.

Already we have reports of pharmacies struggling with an extra 100 antiviral prescriptions per day (p6) – roughly a 50 per cent increase on the daily workload for the average pharmacy. And while we all know that pharmacies have an efficient dispensing process, this level of workload increase is surely a recipe for disaster.

In London, fears that organised crime may target antiviral collection points such as community pharmacies (p6) adds another veneer to the surreal scenario playing out across the country. We’re used to seeing security guards to protect against shoplifters, but the thought of pharmacy staff facing a Tamiflu heist would normally be something you’d expect to see in a Tarantino movie rather than on the local high street.

But while the news has focused on how NHS staff and services are coping with the H1N1 outbreak, there is another equally important factor that seems to have escaped the public radar.

If Andy Burnham’s prediction is right, we could see upwards of three million cases of swine flu in September. And if each patient buys a couple of packets of painkillers, the OTC industry will face its own pressures as it tries to respond to a demand for medicines that has not been seen before.

Quite how manufacturers will be able to budget for the cost of such an increase in production is unclear, but with patients being advised to self-medicate, it is imperative that their needs be considered too as part of the national pandemic plan.

Sir Liam is right – one minute we were watching the television reports of swine flu with curiosity, the next we are having to deal with a full-scale pandemic and, for many of those working in and alongside the health service, the scale and rapid spread of the current outbreak is the biggest challenge they will ever have faced.

Gary Paragpuri, Editor

Pharmacies may get guards to protect London's Tamiflu stocks

Fears that organised crime may target antiviral collection points spark security reviews

Chris Chapman
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Pharmacists on the front line of the swine flu crisis are facing the possibility of guards to protect Tamiflu stocks as demand for the drug soars.

The news comes as longer-term measures, including changes in distribution locations and dispensing fees, are brought in around the country.

In London, security concerns have prompted some trusts to consider employing security guards to protect antiviral collection points.

David Kent, chief executive of Camden and Islington LPC, said the main worry was organised crime targeting collection points to sell the drug on the black market.

He said: "[PCTs] aren't worried about patients, but distribution points will get a lot of product and [they are] worried about organised crime."

A spokesman for NHS London, the strategic health authority for the capital, said: "Each PCT must make its own assessment to organise security if needed to protect their staff and ensure that Tamiflu is stored and distributed to those that have swine flu."

There was sufficient Tamiflu available to avoid "heightened security" and "absolutely no need for armed security", NHS London added.

In other parts of England, pharmacists have reported huge variations in the role PCTs have asked them to take in combating swine flu.

In Brighton, pharmacies that had been collection points were suddenly told Tamiflu distribution would be through one non-pharmacy collection point.

Pharmacist Mina Fedra, whose Westons Pharmacy had received £3.50 per box of Tamiflu dispensed, said the change came suddenly.

He said: "It was out of the blue. I came in over the weekend and the procedures had changed."

In Gateshead, pharmacists have been asked to man non-pharmacy collection points, while in Surrey plans are in place to pay pharmacists a retainer and a £2 per box dispensing fee to continue offering antivirals.

What part have you played in the swine flu pandemic?
haveyoursay@cmpmedica.com

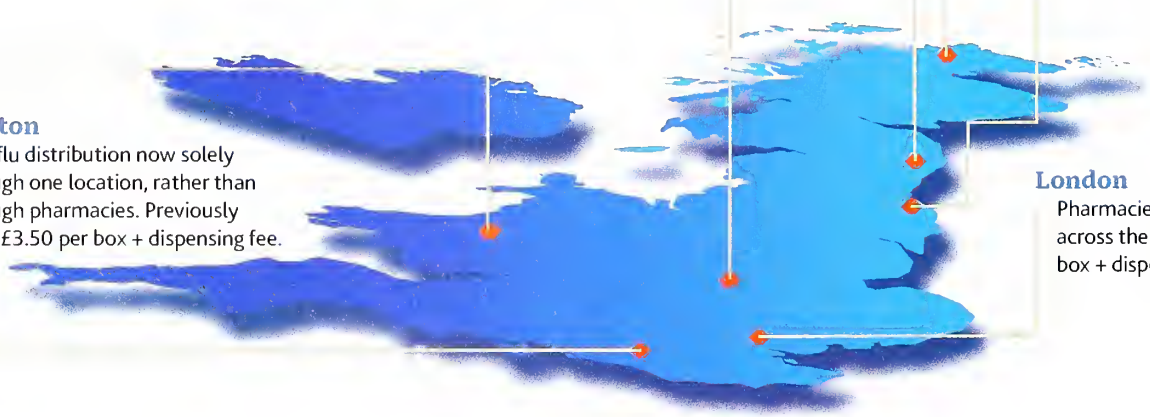
Milton Keynes
Contractors say workload pressure of distributing antivirals is becoming too much.

Gateshead
Pharmacists asked to man non-pharmacy antiviral collection points by PCT.

Scotland
Arrangements made by territorial NHS boards. No suggestion of guards at collection points.

Wales
Each pharmacy assigned 20 courses of antivirals.
Paid: £4 per box + dispensing fee.

North Yorkshire
Pharmacies leading antiviral distribution in some areas. Paid: £2 per box + dispensing fee.



Brighton
Tamiflu distribution now solely through one location, rather than through pharmacies. Previously paid: £3.50 per box + dispensing fee.

London
Pharmacies involved in distributio across the capital. Paid: £3.50 per box + dispensing fee.

Contractors swamped by antiviral demand

PSNC has warned that community pharmacy will not be the best location for Tamiflu distribution at the height of the swine flu pandemic.

The comments came as one pharmacy acting as a collection point in Milton Keynes told C+D the additional pressure was already becoming too much.

Barbara Parsons, head of pharmacy practice at PSNC, confirmed that some pharmacies were now being used as transitional antiviral collection points. But she said many would not be able to cope with the high volume of patients anticipated at later stages in the pandemic.

Ms Parsons said: "Ideally PCTs should be looking at opening up the larger non-pharmacy distribution centres to take the pressure off pharmacy."

Steve Allan, managing director at Cox & Robinson, which has two pharmacies distributing Tamiflu in the Milton Keynes area, said one pharmacy was already seeing around 100 antiviral prescriptions per day and was struggling. "We've got one member of staff doing nothing but Tamiflu all day... it's hard in terms o capacity," he said.

Mr Allan said the group had started talking to the PCT about easing the pressure by getting more pharmacies to help. **ZS**

Walkout threats over Responsible Pharmacist

Employees prepared to quit because of fears over rules change

Jennifer Richardson
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One in five pharmacists intends to leave the profession before the Responsible Pharmacist (RP) regulations come into force, a Pharmacists' Defence Association (PDA) survey has found.

Twenty-two per cent of respondents claimed they would retire before implementation or seek not to work until they can assess the regulations' impact.

More than 2,000 PDA members responded to the survey in a week. The vast majority, 93 per cent, said the profession would not be fully ready for the regulations by October 1, when they are due to replace the concept of personal control.

Just days after going live, a petition launched by locum Graeme Stafford to delay implementation of RP had almost 500 signatures.

The PDA hopes this evidence will help persuade the government to delay RP, to give the profession sufficient time and resources to prepare. The PDA believes the regulations contain "very significant fundamental flaws" that need to be revisited before implementation, including discrepancies around RP absences from the pharmcy.

"Practical concerns have been largely disregarded not only by the Department of Health but also by the RPSGB," the PDA said. Chairman Mark Koziol urged the RPSGB to "get with the programme" and back its campaign to delay RP. He told C+D: "The chances of success will be much greater if the Society gets on board."

The Society said it had not received a "formal request" from the PDA to join the campaign. "Council would need to consider the reasons put forward for delaying the implementation... before making a decision to join any such campaign," a spokesperson said.

The Society was "continuing to help pharmacists and their employers understand the implication of the regulations", she added.

To view the PDA survey and sign the petition go to www.chemistanddruggist/news

RP results by numbers

93% of pharmacists believe the profession will not be fully ready for RP by the October 1 implementation date

90% feel there has been no appropriate training to prepare them for RP

22% intend to retire before October 1 or not work until they can assess the impact of RP

Source: PDA survey, July 2009

The answer is...

To celebrate C+D's 150th birthday this September, we look back at the events of 1859

The Suez canal

Construction begins on the vital waterway that allows ships to travel between Europe and Asia without having to navigate Africa. More birthday fun and games on p30.

1859

RPSGB has clear path ahead after clearing Charter hurdle

The RPSGB will push ahead with plans to deliver a new professional leadership body after securing the yes vote needed to make Charter changes.

Seventy eight per cent of members approved the proposals, which needed a two thirds majority to pass. A total of 10,698 pharmacists voted – 22 per cent of the RPSGB's members.

The victory mean that the RPSGB can proceed with plans to form the new professional leadership body.

Speaking exclusively to C+D, Society chief executive Jeremy Holmes said: "We've been given a very clear mandate and direction of travel. We will continue with the engagement process and engagement groups, moving towards the new structure."

Mr Holmes said he was pleased with the number of pharmacists who registered their vote.

He did not believe the turnout of 22 per cent could be used as a yardstick to judge the number of pharmacists who would join the professional leadership body.

The last RPSGB Council election held in May saw a turnout of around 15 per cent.

The Charter changes will come into force when the Society hands over regulatory powers to the General Pharmaceutical Council in Spring 2010. The Society will then form the new professional leadership body. **CC**

Did you vote on the Charter changes? If not, why not?

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DH chief lobbies PCTs

England's chief pharmaceutical officer has written to PCTs to promote community pharmacy-based NHS Health Checks. Keith Ridge encouraged discussion between PCTs and LPCs, and said there was "a significant opportunity for pharmacy to play a major part" in delivery of the checks.
www.chemistanddruggist.co.uk

O'Brien feels the pressure

MPs have piled the pressure on pharmacy minister Mike O'Brien in his opening exchanges in the Commons. Mr O'Brien was quizzed by colleagues on drugs shortages, the decriminalisation of dispensing errors and generic substitution.
www.chemistanddruggist.co.uk

Counterpart first

Katy Tough from Day Lewis pharmacy in Worthing has become the first medicine counter assistant to complete C+D's new Counterpart training course. Ms Tough successfully completed all 14 modules in the new course in just eight weeks.
www.chemistanddruggist.co.uk

Power to the people

Pharmacists striving to form local hubs for the new professional leadership body have praised the new groups as giving powers back to members. Around 40 pharmacists gathered at the University of Hertfordshire last week to discuss forming a local practice forum (LPF).
www.chemistanddruggist.co.uk

Rituximab approval

Nice has recommended rituximab for the treatment of chronic lymphocytic leukaemia (CLL), the most common form of the cancer. There are an estimated 20,000 UK patients with the condition.

Unplanned pregnancies

Almost four in 10 women with an unplanned pregnancy did not use contraception, a survey has found. The Marie Stopes International survey also found one third of women with an unplanned pregnancy who used protection reported technical difficulties with the contraceptive.

Dispensary talk

Has swine flu caused a rise in your OTC medicine sales?

"Yes, I'd say significantly. We're an antiviral collection point. Thermometers are going through the roof, and so are tissues."
Geoff Ray, Total Health Pharmacy, Watton, Norfolk

"I don't think so, not in line with flu things. We haven't seen a significant change. But we've seen increased sales of the hand gel."
Aina Osunkunle, K and A Pharmacy, Gateshead

Web verdict

Yes 72%

No 28%

Armchair view: Despite the varying role of pharmacies around the country in fighting swine flu, most respondents report that the pandemic has increased OTC sales.
This week's question: Should pharmacies be antiviral collection points? Vote at www.chemistanddruggist.co.uk

Generic substitution hit by industry backlash

Report says switching could increase workload and costs

Zoe Smeaton
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Explaining substitutions would be a "significant time investment" for pharmacists

Plans for pharmacists to be involved in automatic generic substitution have come under fire from experts who say the proposals must be subject to a public consultation.

A report warned the scheme could heap extra work onto pharmacists and harm patients.

Report signatories included a community pharmacist and figures from leading Parkinson's Disease charities.

Under government proposals, from January 2010 pharmacists could have to dispense generic alternatives to prescribed branded drugs unless prescribers tick a box prohibiting switches.

The group warned that to ensure patients understood their new medicines, pharmacists could be forced to explain substitutions and their implications, requiring a "significant time investment".

Substitution could also reduce adherence to treatments and increase NHS costs, the report added.

Croydon pharmacist Andrew McCoig said pharmacists could lose customer loyalty if they were seen to be dispensing "cheap options". "Patients are wary of different drugs and loss of quality, particularly when being treated for chronic conditions," he explained.

The group has also launched a petition calling on the Prime Minister to exclude epilepsy drugs from generic substitution.

Switching between versions with varying levels of active ingredients could have negative impacts on health, the group warned.

The petition had more than 4,000 signatures as C+D went to press.

The DH has pledged discussions with pharmacists before introducing generic substitution. PSNC said talks were under way. It also wanted to ensure plans were manageable.

The report was funded by Norgine, a pan-European pharmaceutical company. See more at www.chemistanddruggist.co.uk

AAH targets 1m consumers with national PR campaign

AAH has launched a national consumer marketing campaign to champion community pharmacy to the UK public.

The initiative follows research that revealed 46 per cent of people couldn't remember ever going to a pharmacist for advice.

The All About Health initiative's centrepiece is a consumer website with health check programme, symptom checker, health encyclopaedia and information about pharmacy services.

People will be directed to the site by advertising in lifestyle magazines such as FHM and Red, and on AAH vans. The wholesaler also aims to target one million consumers directly through partnerships with other organisations.

AAH members will be charged £10 a month to join the initiative. As well as benefiting from the national marketing campaign, they will be able to create personalised websites for their pharmacies, linked to the All About Health site by its pharmacy locator.

They will receive POS material, posters and a consumer magazine for customers.

AAH group managing director Mark James said the initiative would ensure "even the smallest and most remote pharmacy can market themselves effectively".

All About Health was backed by the Patients Association. Director Katherine Murphy said: "It provides a healthcare pathway which should strengthen the link between patients and community pharmacies. That can only be a good thing."

Visit All About Health at www.allabouthealth.org.uk. **JR**

LPC overhaul sparks unease

PSNC proposals to allow non-pharmacists to sit on LPCs have sparked controversy in the sector.

The plans form part of a new model LPC constitution that the committees are preparing to discuss and hold contractor votes on.

Graham Phillips, non-executive director of the Independent Pharmacy Federation, said he was "certainly opposed" to non-pharmacists being on LPCs. He said the sector had already seen "too much bullying by non-pharmacists" such as company shareholders, whose concerns about investments could shift the agenda away from pharmacy and patient care.

PSNC said allowing non-pharmacists to sit on LPCs would mean contractors could put forward "the best person for the job of representing contractors". **ZS**

Emollients - the key to effective eczema management[1]

Emollient therapy protects and restores the skin's natural barrier function, which is deficient in people with eczema. This reduces both the frequency and severity of eczema flares.

Many patients with mild to moderate eczema can manage their condition with emollients alone,[2] but emollients need to be used as frequently as possible to have maximum effect.[2] Commonly, however, people do not use sufficient emollient because they are not given appropriate advice on how to apply large enough quantaties.[3]

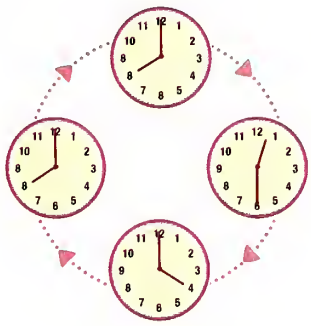
Pharmacists can facilitate adherence

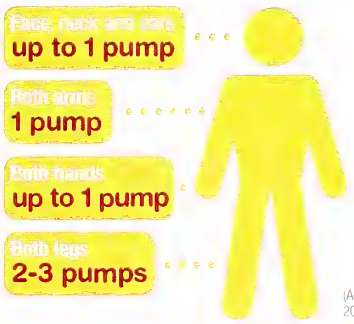
Two important factors in facilitating adherence are an understanding of how treatment works and a recognition that the treatment is working.

Latest guidance from NICE recognises the importance of education in helping people with eczema to adhere to treatment.[1] Pharmacists are ideally placed to reiterate and build on education provided to patients by their GP or nurse.

Patients visiting the pharmacy can therefore usefully be reminded to apply their emollient:

- Every day, every three to four hours, even when skin is clear[4]
- In sufficient quantities
  - Skin should be shiny without residue
  - Far more emollient is required than a topical steroid [10:1 ratio][4]





(Adapted from Dunning G. Nursing Times 2005; 101 (4) 55-56)

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At Schering-Plough, we're keen to help pharmacists support people with eczema, which is why we've developed Eczpert, a FREE online education programme for pharmacists.

Eczpert provides comprehensive information about eczema, its treatment – including benefits of the MUR for eczema patients, providing support to patients and reducing the impact of eczema; and giving you 12 hours of CPP accredited Continuing Professional Development (CPD).

Diprobase Abbreviated Product Information
Uses: Diprobase Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as diluents for topical steroids. Diprobase products are recommended for the symptomatic relief of red, inflamed, damaged, dry or chapped skin, the protection of raw skin areas and as a pre-bathing emollient for dry/eczematous skin to alleviate drying effects. **Dosage:** The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generally, Diprobase Cream and Ointment can be used as often as required. **Contra-indications:** Hypersensitivity to any of the ingredients. **Side-Effects:** Rarely, mild skin reactions have been observed. **Package Quantities:** Cream: 50g tubes, 500g pump dispensers, Ointment: 50g tubes. **Basic NHS Costs:** Cream: £1.30 (50g), £6.58 (500g); Ointment: £1.30 (50g). **Legal Category:** GSL. **Marketing Authorisation Numbers:** Cream: 0201/0076, Ointment: 0201/0075. Further information available upon request from Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW. **Date of Revision:** February 2009

References: 1. National Collaborating Centre for Women's and Children's Health (2007) Atopic eczema in children: Management of atopic eczema in children from birth up to 12 years old. (NICE Full guidance). London, December 2007 www.nice.org.uk **2.** Cork, MJ (1997) The Importance of Skin Barrier Function. J Dermatol Treat, 8, S7-S13 **3.** Clark, C & Hoare, C (2001) Making the most of emollients. Pharm J, 226, 227-229 **4.** PCDSBAD (February 2006) Guidelines for the management of atopic eczema http://www.eGuidelines.co.uk (Accessed June 2009) **5.** Diprobase SPCs (Accessed June 2009) www.emc.medicines.org.uk

Diprobath Abbreviated Product Information
Diprobath is a liquid preparation for external use as a bath additive. It contains Light Liquid Paraffin Ph.Eur 46% w/w and Isopropyl Myristate BP 39% w/w. **Uses:** As a bathing emollient for the treatment of dry skin conditions and hyperkeratoses including dermatitis and eczema. **Dosage:** 25ml (2.5 capfuls) to an adult size bath (approx. 100 litres) or 10ml (1 capful) for children's baths (approx. 25-30 litres). For particularly dry skin, these quantities may be doubled. The frequency and duration of bathing will depend on the nature of the condition. **Contra-indications, Warnings:** Hypersensitivity to the ingredients contra-indicates use. Patients should be advised to use care when entering or leaving the bath which may be more slippery than usual. **Package Quantities:** 500ml bottle. **Basic NHS Costs:** £6.84 **Legal Category:** P. **Marketing Authorisation Number:** 0201/0174. Further information available upon request from Schering-Plough Ltd, Shire Park, Welwyn Garden City, Herts, AL7 1TW, England. **Date of Revision:** January 2009

Please refer to the full SPC texts before prescribing these products

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk
Adverse events should also be reported to Schering-Plough Drug Safety Department on +44 (0)1707 363773

Code: DIP/09-558
Date of preparation: June 2009

Schering-Plough

Charity: pharmacy can defuse hepatitis C crisis

Thousands risk "irreversible" damage unless screening role increased

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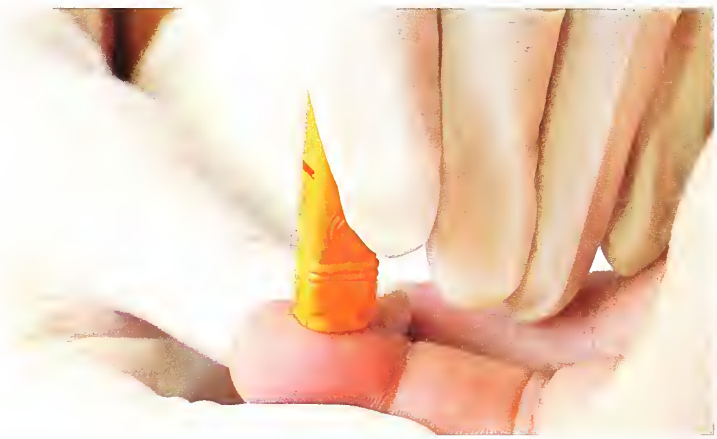

Pharmacy-based hep C pilot better than GP testing, according to early results

PCTs should work with community pharmacies to tackle England's hepatitis C crisis, a leading charity has said.

Seventy per cent of the country's strategic health authorities (SHAs) were failing to implement the government's strategy for managing the deadly virus, research by The Hepatitis C Trust found.

The study highlighted a need for SHAs to encourage PCTs to work with pharmacies in their area to diagnose more sufferers, the Trust told C+D. There were over 100,000 people in England who did not know they were infected, the study estimated.

"Improving access to testing in the community is vital if we are going to diagnose many of these people before it is too late and their livers are irreversibly damaged," said Jane Allen, the Trust's parliamentary and policy advisor.

A hepatitis B and C screening pilot in community pharmacies across five PCTs, which launched in May (C+D, May 16, p5), was "going well", Ms Allen added. "Results so far show a much higher positive diagnosis rate of hepatitis B and C than occurs through GP testing."

Hep C testing role

A Scottish health board has called on community pharmacies to help increase uptake of hepatitis C testing.

NHS Lothian believes community pharmacies are "ideally placed" to tackle the disease and other blood borne viruses including hepatitis B and HIV.

The board has been running training sessions at local pharmacy meetings to help pharmacists raise awareness among those at risk and signpost patients to testing and support services.

It has also launched a hepatitis and HIV screening pilot in one Edinburgh community pharmacy, as part of the Scottish Government's Pharmore project to explore new services.

NHS Lothian said it recognised the "important contribution" community pharmacy could make "due to the regular contact and good relationship they already have with this client group".

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How Portman is helping businesses to prosper

Rehan Nawaz is an independent pharmacist who has been able to expand his business with the help of Portman Asset Finance. Mr Nawaz, who believes that independent pharmacies must look and feel good in order to compete on the high street, has undertaken refits at his sites in Northampton, Leicester and Rotherham.

"Portman Asset Finance behaves more like a partner or business angel than a finance company. From day one they want to help and their service is very quick, very helpful and hassle free. They have stood shoulder to shoulder with me at every stage."

Mr T REHAN NAWAZ BPharm(Hons) DipCPharm MRPharmS • Director, Pharmasurge Partnerships

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Portman Asset Finance provides pharmacies with a tailored package of finance options to cover the full range of shop fittings and equipment. Alex Read, MD at Portman explained: "Consumer

expectations have increased dramatically and it is more important than ever to deliver a memorable retail experience.

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We can provide funding to assist pharmacists purchasing their first premises, those expanding an existing business or even the refinancing of shop fits providing they were carried out within the last 12 months."

"For pharmacies to take over some GP functions it's essential that they provide the facilities required by their Primary Care Trust. We are working alongside Portman to help pharmacies meet those standards and for them to secure important new revenue streams."

Peter Faux, Managing Director, Crescent Retail Design Ltd

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With all independent businesses finding it increasingly difficult to secure bank credit, the benefits of Asset Finance have never been greater, as Portman's Alex Read explained: "Not only do our customers safeguard their cash flow and cash reserves but they can also offset 100% of their monthly payments against their tax liability." He added: "The service we provide is customer-led. We react immediately to requests, deal personally with our clients, provide finance within short-time scales and never, ever behave as if we are doing our clients a favour!"

Portman
Asset Finance Limited

To talk to a member of our Pharmacy Team call **0844 800 88 25**
pharmacy@portmanassetfinance.co.uk
www.portmanassetfinance.co.uk

Didget makes glucose testing child's play

Bayer Diabetes Care is launching a blood glucose meter for children with diabetes that taps into their passion for video games.

The Didget meter can be connected directly to Nintendo DS and Nintendo DS Lite gaming systems. Available from August, it is based on Bayer's Contour system and uses the same technology and test strips.

The meter is designed to help children aged five to 14 manage their diabetes by rewarding them for building consistent blood glucose testing habits and meeting personalised glucose target ranges. Kids are awarded points that they can use to unlock new game levels and customise their gaming experience.

Bayer says the product was developed to directly address the challenges facing kids with diabetes and their parents. "The meter offers play with purpose to encourage kids to regularly monitor their blood glucose and begin to view regular testing as fun," says head of Bayer Medical Care Sandra Peterson.

The product comes with a full length adventure game and mini game arcade.

It will also connect to Bayer's Didget World at www.bayerdidget.co.uk, a new password-protected web community.

Bayer is working in partnership with Juvenile Diabetes Research Foundation and £5 from the sale of every meter will be donated to the Foundation.

Price: £29.00
Bayer Diabetes Care
Tel: 01635 563000

PillGlide will help the tablets go down

FlavorMaster (UK) is planning a September launch for a flavoured spray developed to give relief to those who suffer from dysphagia when taking tablets and capsules.

PillGlide is supplied in a small container designed to be sprayed into the mouth to help tablets or capsules to slide down the throat.

Developed by a pharmacist, the product is a registered Class 1 medical device manufactured by a US manufacturer of flavourings for paediatric medicines.

The ingredients include purified water, glycerine, sorbitol and natural and artificial flavours. The product comes in a choice of four flavours.

Over 25 per cent of the UK population have problems swallowing and many solid medicines are converted to liquid to make ingestion possible, says FlavorMaster.

The company says the spray is

suitable for children learning to swallow tablets and can also aid taking pills and capsules that have an unpleasant taste.

The product is being launched with a buy one, get one free offer.

Price: £9.49/30ml (300 sprays)
FlavorMaster (UK)
Tel: 01747 855348

Prostap update

Takeda UK is now responsible for the distribution of Prostap SR and Prostap 3 in the UK. Prostap (leuprorelin acetate) is licensed for all stages of prostate cancer. The company says that as part of the recent PPRS pricing reforms, Prostap prescribing costs have now been significantly reduced.
Takeda UK; tel: 01628 537900

Beclazone plans

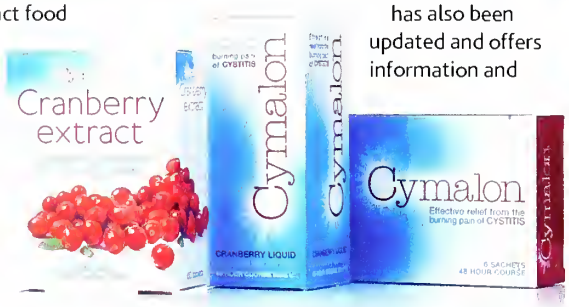
Teva UK will discontinue all strengths of its Beclazone Easi-Breathe (Beclometasone dipropionate) inhalers from September 30. The company said supplies of the standard pMDI inhalers will be available until the first quarter of 2010, based on current demand. Teva is encouraging healthcare professionals to transfer patients to alternative products.
Teva UK; tel: 0800 590 502

Fresh look for Cymalon

Actavis is introducing an eye-catching new look for its Cymalon cystitis brand.

Cymalon Sachets and Liquid now have fresh new packaging designed to convey a sense of relief from the burning pain caused by cystitis.

The company is also extending the range with the launch of a cranberry extract food supplement.



Cymalon Cranberry Extract contains 5,000mg of cranberries in each tablet and is formulated to help consumers maintain a healthy urinary system.

Richard Hollies, Actavis OTC director, says the new food supplement will complement the company's existing range of cystitis products.

The range will be supported by a £1 million advertising campaign in women's magazines from September until December. The campaign aims to raise awareness of Cymalon as an effective treatment for the relief of the burning pain of cystitis, says Actavis.

The Cymalon website at www.cymalon.co.uk has also been updated and offers information and practical advice to sufferers of cystitis.

Price: cranberry extract tablets £4.95/60
Actavis UK
Tel: 0800 373573

Retail talk

Did the recent heatwave make an impact on your sales of suncare products?

Yes 58%

No 42%

Off the shelf view:
Around six out of 10 of pharmacies saw a rush to buy suncare products when temperatures in the UK soared above many European hotspots. But the heatwave already seems like a distant memory – you would probably have done better selling umbrellas in the last fortnight!

This week's question:
Are you selling more OTC medication for flu symptoms than normal at this time of year? Vote at **www.chemistanddruggist.co.uk/prodnews**

Leuprorelin: the world's most used LHRHa

Prostate Cancer is the most common cancer in men in the UK with over 34,000 new cases diagnosed each year[1]

Takeda, one of the world's leading research based Pharmaceutical Companies, discovered and developed the first LH-RH agonist, Prostap (leuprorelin acetate) in the mid 1970s. Leuprorelin is the world's most used LHRHa and is licensed for all stages of prostate cancer[2].

What's new at Takeda UK Ltd?

On the 1st July 2009 the Marketing Authorisations for Prostap SR and Prostap 3 in the UK returned to Takeda UK Ltd., with full responsibility for the distribution of the products being assumed.

The transfer of Prostap is of significant importance to Takeda given the Company's commitment to working with clinicians and healthcare professionals to deliver more effective therapies for cancer patients.

Now even better value

As part of the recent PPRS pricing reforms, we are pleased to inform pharmacists that Prostap prescribing costs have now been significantly reduced[3,4].

Medical Support

Medical queries should be directed to Takeda UK Ltd.
Adverse events and product complaints should be reported to Takeda UK Ltd. on 01628 537900 or email drugsafety@takeda.co.uk

You can also report directly to the Medicines and Healthcare products Regulatory Agency at www.yellowcard.gov.uk

Prostap
leuprorelin acetate depot injection

Date of preparation July 2009, PS090622

ABBREVIATED PRESCRIBING INFORMATION

PROSTAP® SR/PROSTAP® 3 Leuprorelin Acetate Depot Injection 3.75mg/11.25mg. **Presentation:** Prolonged release powder for suspension for injection after reconstitution with the Sterile Vehicle. Prostap SR Powder: contains 3.75mg of leuprorelin acetate, equivalent to 3.57mg base. Prostap 3 Powder: contains 11.25mg of leuprorelin acetate, equivalent to 10.72mg base. **Indications:** Prostap SR/Prostap 3: As an adjuvant treatment to radical prostatectomy in patients with locally advanced prostate cancer at high risk of disease progression; As an adjuvant treatment to radiotherapy in patients with high-risk localized or locally advanced prostate cancer; Locally advanced prostate cancer, as an alternative to surgical castration; Metastatic prostate cancer; Management of endometriosis including pain relief and reduction of endometriotic lesions. Prostap SR is also indicated for endometrial preparation prior to intrauterine surgery; preoperative management of uterine fibroids to reduce their size and associated bleeding. **Dosage and Administration:** Prostate Cancer: Prostap SR: 3.75mg administered every month as a single subcutaneous or intramuscular injection. Prostap 3: 11.25mg every 3 months as a single subcutaneous injection. Do not discontinue when remission or improvement occurs. Therapy should be monitored clinically. If response appears to be sub-optimal, it should be confirmed that serum testosterone is at castrate level. **Endometriosis:** Prostap SR: 3.75mg administered as a single subcutaneous or intramuscular injection every month. Prostap 3: 11.25 as a single intramuscular injection every 3 months. Treatment should be for a period of 6 months only and initiated during the first 5 days of the menstrual cycle. If appropriate, hormone replacement therapy (HRT - an oestrogen and progestogen) should be co-administered with Prostap to reduce bone mineral density loss and vasomotor symptoms. **Endometrial Preparation Prior to Intrauterine Surgery:** Prostap SR: 3.75mg as a single subcutaneous or intramuscular injection 5-6 weeks prior to surgery. Therapy should be initiated during days 3 to 5 of the menstrual cycle. **Preoperative management of uterine fibroids:** Prostap SR: 3.75mg as a single subcutaneous or intramuscular injection every month, usually for 3-4 months but for a maximum of six months. **Elderly:** As for adults. **Children** (under 18 years)**: Not recommended** - safety and efficacy in children have not been established. For chronic administration, the injection site should be varied periodically. **Contraindications:** Hypersensitivity to any of the ingredients or to synthetic GnRH or GnRH derivatives. Women: Lactation, pregnancy, undiagnosed abnormal vaginal bleeding. **Precautions and Warnings:** General: Development or aggravation of diabetes may occur; therefore diabetic patients may require more frequent monitoring of blood glucose. Hepatic dysfunction and jaundice with elevated liver enzyme levels have been reported. Therefore, close observation should be made and appropriate measures taken if necessary. The ability to drive may be impaired due to visual disturbances and dizziness. Men: A transient rise in levels of testosterone may occur initially. This may be associated with tumour flare, sometimes manifesting as systemic or neurological symptoms. These symptoms usually subside on continuation of therapy. An anti-androgen may be administered to reduce the risk of flare (see SmPC, section 4.4). Patients at risk of ureteric obstructions or spinal cord compression should be closely supervised in the first few weeks of treatment. These patients should be considered for prophylactic treatment with anti-androgens. Should urological/neurological complications occur, these should be treated appropriately. Women: Whilst ovulation is usually inhibited during therapy, contraception is not ensured. Patients should therefore use non-hormonal methods of contraception. During the early phase of therapy, sex steroids temporarily rise, possibly leading to an increase in symptoms, which dissipate with continued therapy. Menstruation should stop with effective doses of Prostap, therefore the patient should notify her physician if regular menstruation persists. The induced hypo-oestrogenic state may result in a small loss in bone mineral density over the course of treatment, some of which may not be reversible. However, during one six-month treatment period, this bone loss should not be important. For patients with major risk factors for decreased bone mineral content Prostap may pose an additional risk. Before treating these patients for fibroids, their bone density should be measured, and where results are below the normal range, Prostap therapy should not be started. In women receiving GnRH analogues for the treatment of endometriosis, the addition of HRT (an oestrogen and progestogen) has been shown to reduce bone mineral density loss and vasomotor symptoms. Prostap may cause an increase in uterine cervical resistance. This may result in some difficulty in dilating the cervix for intrauterine surgical procedures. Diagnosis of fibroids must be confirmed prior to treatment by laparoscopy, ultrasonography or other investigative technique. In women with submucous fibroids there have been reports of severe bleeding following administration of Prostap as a consequence of acute submucous fibroid degeneration. Patients should be warned of the possibility of abnormal bleeding or pain in case earlier surgical intervention is required. **Side Effects:** General: Adverse events which have been reported infrequently include peripheral oedema, pulmonary embolism, hypertension, hypotension, palpitations, fatigue, muscle weakness, diarrhoea, nausea, vomiting, anorexia, fever/chills, headache (occasionally severe), hot flushes, arthralgia, myalgia, dizziness, insomnia, depression, paraesthesia, visual disturbances, weight changes, jaundice, increases in liver function test values, and irritation at the injection site. Changes in blood lipids and alteration of glucose tolerance have been reported. Thrombocytopenia, leucopenia and infarction of pre-existing pituitary adenoma have been reported rarely. Hypersensitivity reactions including rash, pruritus, urticaria, and, rarely, wheezing or interstitial pneumonitis have also been reported. Bone mass reduction may occur. Anaphylactic reactions are rare. Spinal fractures, paralysis and worsening of depression have been reported. Men: If tumour flare occurs, symptoms and signs due to disease e.g. bone pain or urinary obstruction may also occur. Other side effects include impotence, decreased libido, hot flushes and sweating. Gynaecomastia has been reported occasionally. Women: Side effects reported are mainly those related to hypo-oestrogenism e.g. hot flushes, mood swings including depression (occasionally severe), and vaginal dryness. Breast tenderness or a change in breast size, and hair loss, may occur occasionally. A small loss in bone density may also occur, some of which may not be reversible (see Precautions and Warnings). Vaginal haemorrhage may occur due to acute degeneration of submucous fibroids. **Legal Category:** POM. **Package Quantities:** Prostap SR: Single injection pack. One vial containing 3.75mg leuprorelin acetate as microcapsule powder, one prefilled syringe containing 1ml sterile vehicle, three syringe needles (two 23 and one 21 gauge); Prostap 3: Single injection pack. One vial containing 11.25mg leuprorelin acetate as microcapsule powder, one prefilled syringe containing 2ml Sterile Vehicle, two 23 gauge needles. **Basic NHS Cost:** Prostap SR £75.24; Prostap 3 £225.72. **Marketing Authorisation Numbers:** Prostap SR: PL 16189/0008; Prostap 3: PL 16189/0009; Sterile Vehicle: PL 16189/0010. For full prescribing information and details of other side effects see Summary of Product Characteristics. **Full prescribing information is available on request from:** Takeda UK Limited, Takeda House, Mercury Park, Wooburn Green, High Wycombe, Bucks. HP10 0HH. UK. Telephone: 01628 537900; Fax: 01628 526617. **Date of Prescribing information:** 01/07/2009. ®Registered Trademark of Takeda. PS090504

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk
Adverse events should also be reported to Takeda UK Ltd. on 01628 537900.

[1]http://info.cancerresearchuk.org/cancerstats/types/prostate/. Accessed 16/06/09
[2]IMS Knowledge Link (MIDAS data Q4 2008). [3]Mims, January 2009 [4]Mims, June 2009

Get us out of Tamiflu distribution, quick

> I LOVE TO CHAMPION NEW ROLES FOR PHARMACY, BUT I DON'T THINK THIS IS ONE OF THEM

The swine flu pandemic is finally in full flow and, despite years of planning, those in charge of the response seem to be making things up as they go along. Meanwhile, I'm no better informed about what's going on than the general public, whose level of interest ranges from sheer panic to complete indifference.

Patients and contacts are unclear whether they should stay at home or carry on as normal. Some are so unfazed that they haven't even bothered to collect the Tamiflu that we've dispensed for them. I've heard of a locum pharmacist continuing to work despite having the flu. I can understand that – nobody's going to compensate them for lost earnings.

The government is now launching a swine flu helpline that will diagnose and prescribe Tamiflu so people don't have to bother their GP. Good idea, but I've not heard of that 'plan' mentioned before. And if GPs can be cut out of the swine flu loop for the greater good, I suggest that pharmacists should be too.

We are distributing increasing amounts of Tamiflu in a system that won't hold up for much longer, particularly if my staff and I become ill. It's not the weight of work that we're struggling with but the weight of paperwork.

A customer with a script for Tamiflu could normally be in and out of the pharmacy in under 60 seconds, but this Heath Robinson distribution system we are using takes 10 times that. In a national emergency my skills should be put to better use than pen pushing.

This constantly changing paper-based system involves faxes into and out of the pharmacy, duplicates in the post, maintaining a running stock balance, and recording details of both the patient and their flu friend. All this could have been recorded on the PMR via a prescription-based system in a fraction of the time. All we would need to do differently is send the scripts to the PCT instead of the PPA for payment and analysis. The authorities have had years to plan for these systems, but it feels like they were dreamt up only a few weeks ago.

I have to wonder whether it's all worth it for a largely untried drug that probably isn't that effective anyway. If things get really bad my priority must lie with repeat prescriptions over Tamiflu distribution even though I expect 'the plan' to have changed several times by then.

I love to champion new roles for pharmacy, but I don't think this is one of them. The increasingly fragile pharmacy network needs to be preserved for the distribution of other medicines and delivery of essential services. And my chronically ill patients can do without unnecessary contact with carriers of the virus. Therefore I suggest keeping us out of the Tamiflu loop and using central collection points manned by administrators.

Learning from our dispensing errors

The old lady slept on the ward for two days. Her family, dutifully visiting, were puzzled, and asked the nurse why their previously alert mother was so deeply asleep. "Ah," said the ward sister, "it's the healing process".

It was not. She was sleeping because I had poisoned her. I had sent up promazine 25mg tablets labelled as 5mg tablets, and the nurse had started to give her five times the prescribed dose.

Luckily the nurse thought five tablets odd and did not give the last one. She told the ward sister, who told me and conspired with other nurses and doctors to cover my mistake. I'm eternally grateful.

This was the first dispensing error I knew I had made, and is still seared on my memory, nearly 30 years later. I don't know how many other errors I made. The problem is, because of the way errors happen, the person making them rarely knows; self-report identifies less than one in 100 errors.

How often do dispensing errors happen in your pharmacy? My colleague Professor Bryony Franklyn worked with community pharmacists to agree what was a dispensing error. For example, using your clinical nous to change a label was not considered an error. However, spelling the patient's name incorrectly, or giving the wrong amount, were examples of minor errors.

In each of 11 pharmacies a sample of around 200 items, bagged and ready to be handed to patients, were examined and compared to the prescription. Around one in 30 items contained an error. Most were trivial in their consequences, however, all pharmacies had some errors and some were serious. How would you have fared?

Thankfully, dispensing errors look like they will be decriminalised, but what then? Do we then go on making the same number of errors in a blissfully decriminalised state? Or do we want to trap, identify and learn from errors for the sake of patients, the profession, and ourselves?

Patient safety campaigns are beginning to do these things in secondary care. Why shouldn't pharmacy lead in primary care? We can lead in measuring and learning from our errors, using the latest quality management techniques, which do not take too much time and are easy to learn.

The starting place is to know how you are doing at the moment, so what are you waiting for? Open some bags and start checking!

Professor Nick Barber, Centre for Medication Safety and Service Quality, The School of Pharmacy, University of London

> I HAD SENT UP PROMAZINE 25MG TABLETS LABELLED AS 5MG, AND THE NURSE HAD STARTED TO GIVE HER FIVE TIMES THE PRESCRIBED DOSE

25.07.09

Features

Update

July is Heart Health Month

Throughout July C+D presents its own Heart Health Month with four articles on topics in CVD medicine that describe the heart disease epidemic, risk assessment, and hypertension and cholesterol treatments. See the articles online at www.chemistanddruggist.co.uk/update

Your weekly CPD revision guide Module 1487

CVD guide part 4: cholesterol

Update's Heart Health Month continues with a focus on drugs that might be prescribed after an NHS Health Check

Rosemary Blackie MRPharmS

60-second summary

What are the choices for lowering blood lipids?

Simvastatin 40mg at night for primary prevention if there is no clinical evidence of CVD but a 20 per cent 10-year risk. If there are contraindications or interactions, the dose can be reduced or pravastatin 40mg tried instead. Fibrates, bile-acid sequestrants or ezetimibe are other alternatives.

What if the patient already has CVD?

Increase the dose to 80mg simvastatin if total cholesterol does not fall below 4mmol/l or LDL below 2mmol/l on 40mg. Other alternatives are fibrates, anion exchange resins, nicotinic acid or ezetimibe. People with acute coronary syndrome can be offered simvastatin 80mg or atorvastatin without waiting for blood lipid results.

This article (Module 1487) can help in the following CPD competencies: C1a, C1c, C1d, C1e, C1a, C1b, C3e

This final article in our Heart Health Month describes the treatments that might be offered to patients identified as having high cholesterol levels following NHS Health Checks. The earlier articles looked at lifestyle factors affecting the heart, how pharmacists can assess people for vascular disease risk, and antihypertensives.

Nice published its guidelines on Lipid Modification for the Prevention of Cardiovascular Disease in 2008. It is aimed at those over 40 years and covers primary and secondary prevention. Under 40s should be treated if they are at high risk. Flowchart summaries are available in MIMs as well as the guidelines.[1,2] Simvastatin is the drug of choice, determined by its efficacy and cost, but alternatives can be offered if needed.

Primary prevention

In patients with a 10-year CVD risk over 20 per cent but without clinical evidence of CVD:

- give 40mg simvastatin daily, at night
- give less than 40mg simvastatin or 40mg pravastatin if there are contraindications or interactions
- consider a fibrate or bile-acid sequestrant or ezetimibe if statins are unsuitable.

Nice indicates no target cholesterol level for primary prevention as trials have not studied the effectiveness of achieving targets in this group. However, figures have been set by other authorities, for example NSF says reduce total cholesterol to less than 5mmol/l and LDL to 3mmol/l or 30 per cent less than baseline, whichever is greater.

Secondary prevention

- Simvastatin 40mg should be offered as soon as possible where there is clinical CVD evidence, such as stable angina, peripheral vascular disease, stroke or transient ischaemic attack (TIA).
- This can be increased to simvastatin 80mg where total cholesterol does not fall below 4mmol/l or LDL less than 2mmol/l.
- Consider fibrates, anion exchange resins, nicotinic acid or ezetimibe if this is not tolerated.
- Offer a higher intensity statin, such as atorvastatin or simvastatin 80mg, to people with acute coronary syndrome (ACS) without waiting for results of blood lipids.

As with primary prevention, no study data evaluates the benefits of treating to target for cholesterol levels. The figures for total cholesterol (TC) and LDL are to guide treatment as most people will still not reach the targets even on simvastatin 80mg.[1] Studies comparing statin doses show that using higher intensity statins in stable CVD results in more people stopping tablets because of side effects.[3]

Primary and secondary prevention

The Heart Protection Study (2002) showed that simvastatin 40mg lowered MI risk by over a quarter and is the cheapest statin available.

- Fibrates or bile-acid sequestrants should not be routinely offered as the evidence is "less robust".[4]
- Nicotinic acid, bile-acid sequestrant or fibrate with a statin should not be offered because of lack of evidence or increased side effect risk.
- There is no evidence for fish oils apart from immediately following an MI.
- Atorvastatin should only be considered in ACS.[3]
- Higher intensity statins are not used routinely as they are not cost effective: most people will still not reach the audit target of 4mmol/l TC.[2,4]
- Patient preferences, circumstances and risks and benefits should be considered,[3] but atorvastatin 10mg could be used where there has been intolerance to both simvastatin and pravastatin.[7]

Monitoring

Liver function tests should be carried out within three months and at 12 months.[2] Repeat cholesterol tests are unnecessary, although it can be helpful for some patients to see beneficial effects of medication. Only in ACS is repeat lipid level measuring indicated at three months.[2]

Diabetes

All over the age of 40 should start on simvastatin 40mg, unless there are no other risk factors for CVD, in which case they should be assessed using the UKPDS risk assessor and started on simvastatin 40mg if risk is over 20 per cent.

Those under the age of 40 should be considered for treatment if they have diabetic complications, such as nephropathy or retinopathy, or are at increased CVD risk from factors such as hypertension or family history of CVD.[3]

If TC does not fall below 4mmol/l or LDL below 2mmol/l, an increase to 80mg simvastatin, other

statin or ezetimibe can be tried. This is also the case where there is established CVD.

Statins

These inhibit HMG Co-A reductase, the enzyme involved in cholesterol production. This action reduces liver cholesterol production and increases hepatic LDL receptors, thereby increasing LDL uptake and catabolism.

Numerous studies have shown the benefits of statins in cholesterol reduction, eg the WOSCOPS study showed a 42 per cent reduction in coronary heart mortality in those who had high mean cholesterol levels but no CHD and were taking pravastatin.[6] The 4S study showed the benefits of statins in those with pre-existing CHD and high cholesterol levels, with a 42 per cent reduction in coronary heart mortality.[6]

Where there is no clinical CHD evidence, statins significantly reduce all cause mortality, fatal and non-fatal MI.[7] The 4S and Heart Protection studies reported that 20mg or 40mg simvastatin are appropriate choices where there is CVD.[7]

The Jupiter trial reported that rosuvastatin can be considered where high intensity statins are needed, but the first-line choices are not tolerated or contraindicated. A dose of 20mg was used in this trial, but Nice has indicated it should not be initiated at this dose as it may increase diabetes risk.[8] It has a higher incidence of muscular effects and should be started at 10mg, only increasing to 20mg if needed after four weeks. It reduces atherosclerosis, but the ASTEROID study has not shown that this leads to a reduction in heart attacks or strokes.

STATIN INTERACTIONS

Statins are metabolised by different pathways, which accounts for the ability to use alternatives. For example, atorvastatin is metabolised by cytochrome P450 3A4 and fluvastatin by P450 2C9, whereas rosuvastain and pravastatin are not significantly metabolised by P450.

Patients started on some macrolide antibiotics, such as erythromycin, or azole antifungals should stop the statin for the duration of the course or should have an alternative antibiotic prescribed. Grapefruit juice increases simvastatin levels, so should be avoided. CoEnzyme Q10 may be reduced by statins, but there is conflicting evidence regarding its clinical significance, so supplementing with this enzyme is not recommended.[9]

DOSING

Both simvastatin and pravastatin have short half-lives, so evening dosing is advised as most cholesterol is produced at night. Atorvastatin has a longer half-life of 20 to 30 hours, so can be administered at any time of day.

SIDE EFFECTS

Myalgia and rhabdomyolysis are a class side effect, but the incidence is small: myopathy risk is less than 1 in 10,000 patient years with a standard statin dose and rhabdomyolysis risk about one-third of this.[3] Rhabdomyolysis is potentially fatal, as acute renal failure can occur by accumulation of myoglobin and other muscle breakdown products. If unexplained muscle pain arises, patients should stop taking the statin and return to the GP for creatinine kinase investigation. Risk is increased with higher intensity statins and with rosuvastatin. Fibrates, particularly gemfibrozil, increase the risk of rhabdomyolysis when used with statins. The BNF advises that where fibrates and statins are used together, monitoring of liver function and creatinine kinase should be considered. It adds, gemfibrozil and statins should not be used concomitantly.

The class was subject to an MHRA safety warning in 2008 because of side effect concerns, including interstitial lung disease. Patients experiencing breathlessness, non-productive cough and general deterioration in health should be further investigated and the statin discontinued.

Other side effects shown to be more prevalent than originally thought are depression, sleep disturbance, memory loss and sexual dysfunction. Neuropathy has a risk similar to that of myopathy.

Ezetimibe

The sterol transporter is responsible for the uptake of cholesterol and phytosterols in the intestine; ezetimibe targets this transporter to prevent cholesterol absorption.

It is not licensed for primary prevention because of insufficient evidence in reducing CV event risk, although it does reduce LDL. There have also been queries about cancer risk, but a MeReC Rapid Review this month said analysis of adverse event reports did not find increased risk, although long-term safety is still unclear. Despite this, ezetimibe is an option when statins are contraindicated or at least two other agents are not tolerated. It can be used in ACS or diabetes when maximum statin treatment has failed to reduce cholesterol to target levels. It does not affect the uptake of fat soluble vitamins or other fatty acids. The main side effects include abdominal pain and nausea.

Omega-3 fatty acids

These reduce serum lipid concentrations and have anti-inflammatory and anti-platelet actions because of their competition with arachidonic acid.[6] This means, however, that they should be used with caution in patients with haemorrhagic disorders or those taking anti-coagulants. Some omega-3 supplements contain vitamins A and D so care is needed to avoid toxicity if other vitamin preparations are being taken.

Omega-3-acid ethyl esters are only routinely recommended in those who have had an MI fewer than three months previously and are unable to take at least 7g omega acids per week in the diet. They should be continued for at least four years.

Fibrates

These reduce triglycerides by inhibiting hepatic synthesis and increasing their catabolism. Fibrates also increase HDL by increasing ApoA-I and ApoA-II gene transcription[10] and inhibit bile synthesis and increase secretion of cholesterol in the bile.[6]

It has been shown that fibrates can reduce LDL by 5 to 25 per cent, increase HDL by 10 to 20 per cent and reduce triglycerides by 20 to 50 per cent.[3] They have the best TC reducing effect of all the lipid-lowering agents.

Rhabdomyolysis is less common than with statins, but a myositis-like syndrome can be observed especially in renal impairment.[3] Gemfibrozil should not generally be used together with statins. Also gemfibrozil inhibits many cytochrome P450 enzymes, so care should be taken with interactions.[10]

Bile acid sequestrant (BAS)

These bind bile acids to form non-soluble complexes in the GI tract and increase faecal excretion. This prevents reabsorption and removes cholesterol from enterohepatic circulation. Therefore, BAS treatment reduces the ability of bile acids to solubilise dietary lipids and stimulates the liver to convert endogenous cholesterol into bile acids in an attempt to maintain the bile acid pool size.[10]

There is increased liver LDL receptor activity as well as increased removal of LDL from the blood. BAS can reduce LDL by 15 to 30 per cent[3] with no myopathy risk and can increase HDL by 5 to 15 per cent.[3] They complement other medications as they do not inhibit cholesterol synthesis.[10]

The most common side effect is constipation. Absorption of some medications can be affected (especially digoxin, verapamil, levothyroxine and tetracycline[10]). The effects of warfarin and phenindione can be altered: close monitoring is advised. Other medication should be taken at least one hour before or four to six hours after taking a BSA. Fat soluble vitamin supplements may be required.

Nicotinic acid and acipimox

This is a water-soluble B-complex vitamin[10] that inhibits the synthesis of LDL and TC to reduce LDL and T and increase HDL. However it is not licensed for primary or secondary CVD prevention.[10] Flushing occurs as a result of its vasodilatory properties. Other side effects include abdominal upset, rash and itching.

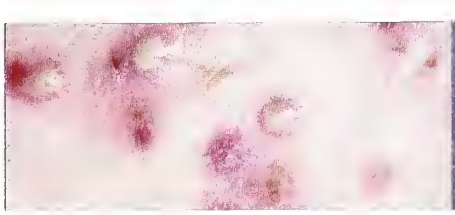
It is titrated upwards over three weeks and can be further increased as necessary. It should be taken at night with a low fat snack.

Acipimox is a member of the nicotinic acid group and may have fewer side effects than nicotinic acid. Again, the main side effects are vasodilation, flushing and GI upset. It may be less effective than nicotinic acid and is only recommended for use in certain hyperlipidaemias where there has been inadequate response to other measures.

There are no trials on clinical endpoints, such as CV morbidity and mortality, and it is not licensed for primary or secondary CVD prevention.[10]

Rosemary Blackie is a community pharmacist.

References and further information are online at www.chemistanddruggist.co.uk/update



NEXT WEEK'S UPDATE
The management of psoriasis

CVD guide part 4: cholesterol

Reflect

What is the cholesterol-lowering drug of choice for secondary prevention of CVD? Is ezetimibe suitable in primary prevention?

Plan

This article discusses the cholesterol-lowering medication used in primary and secondary prevention of CVD, including information about the interactions and side effects.

Act

For references and further reading, see the online version of this article on the C+D website at www.chemistanddruggist.co.uk/update

Read the previous Updates on CVD risk (C+D, July 4 and July 11) discussing the importance of cholesterol levels at www.chemistanddruggist.co.uk/update.

Look at the lipid modification flowchart for prevention of CVD on the MIMS website: http://tinyurl.com/kpqprn

Revise your knowledge of lipid-lowering drugs by reading section 2.12 of the BNF.

Update your knowledge of fibrates and ezetimibe on the Patient UK website at www.patient.co.uk/showdoc/40026171 and www.patient.co.uk/showdoc/40025307

The National Prescribing Centre has case studies and a quiz on lipid-lowering therapy: http://tinyurl.com/kp4m56

Evaluate

Are you familiar with the recommended cholesterol-lowering medications used for primary and secondary prevention of CVD? Are you confident in your knowledge of their side effects and interactions?

Practical Approach

Isotretinoin for a teenage girl

David Spencer, pharmacist at the Update Pharmacy, receives a phone call at home from Lara Bond, a family friend.

"David, I'd like your advice," says Lara. "It's about Sarah."

"Is it to do with her acne?" David asks Lara.

"That's right. There's no need to tell you how bad it is, you've been dispensing medication for it for two years now. You know we've been through just about everything available without much success. Well, the hospital dermatologist now wants to put her on something called isotretinoin. He says that it's usually very effective, but that as she's a girl there are some specific conditions she's got to agree to before he'll start the treatment. And it's those that are bothering me."

"I think I know what they are, but go on."

"Yes, she's going to be treated as if she was a sexually active adult and that's very upsetting. You know Sarah, she's only 15, she's a shy girl anyway and with her condition she'll barely step outside the door because she thinks she's repulsive, so there's no chance she's going to start having sex with anyone. And another thing, the dermatologist warned us she might get depressed taking the drug. Her condition's made her depressed enough as it is, I don't want her getting suicidal. I remember a few years ago reading about isotretinoin and suicide in teenagers. David, do you think her taking it is worth the bother and the risks?"

Questions

1. Why are specific conditions necessary for females taking isotretinoin and what are they?

2. What are the special conditions and restrictions for pharmacists dispensing isotretinoin for women of childbearing age?

3. What is the risk of suicide for patients taking isotretinoin?

Answers

1. It is teratogenic; if pregnancy occurs during treatment or in the month following, there is a great risk of very severe and serious malformation of the foetus. Females of child-bearing potential must have a pregnancy test before starting treatment and monthly thereafter until five weeks after ceasing. At least one and preferably two complementary forms of contraception, including a barrier method, should be used throughout treatment. The conditions also apply to women who are not currently sexually active unless the prescriber considers there are compelling reasons to indicate there is no risk of pregnancy.

2. Prescriptions should be limited to 30 days' treatment at a time, with further prescriptions issued only following negative pregnancy tests. Prescriptions should be dispensed within a maximum of seven days of issue.

3. For some years there have been reports linking isotretinoin to depression or suicide in young patients. However, a review of the evidence found no causal relationship, and that the incidence of depression and suicide during isotretinoin therapy may be no greater than for the population in general.[1] Acne itself is sometimes a cause of depression.

This article can help with these CPD competencies:
G1a, G1c, G1d, G1e, G2o
See http://tinyurl.com/68ox7b

References

Magin P, Pond D. Isotretinoin, depression and suicide: a review of the evidence. Br J Gen Pract. 2005; 55: 134–138.

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

Ethical dilemma

Drug dependence and pregnancy

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **ethics@cmpmedica.com**

While in theory the potential for a resident to overdose in a registered care home is small, it can happen. As part of the usual emergency procedures, naloxone, a specific antidote for opiates, may be administered by intramuscular or intravenous injection.

The issues here include:

- responsibility to the resident and unborn child
- use of PGDs
- emergency administration of drugs to save life
- welfare of the unborn child.

The Prescription Only Medicines (POM) Order (Article 7) allows anyone to administer selected POMs, including naloxone, to save life in an emergency. In deciding whether to set up a PGD there is a need to differentiate between a PGD that is for supply and one for administration.

If the care home is licensed for treatment of substance misuse and staffed by qualified nurses, there is no need for a PGD as naloxone should be part of their emergency procedures. If the staff are unqualified, they are not covered by a PGD for administration (even though they can give the drug in an emergency) and would need a PGD for supply in order to obtain a POM. If patients have a supply of their own naloxone, provided under a PGD for supply, then anyone can administer it. The PGD and staff training should address the potential impact that naloxone might have on a pregnant woman and her unborn foetus.

The RPSGB's Code of Ethics states that, when faced with conflicting professional obligations and legal requirements, pharmacists must consider fully the options available, evaluate the risks and benefits, and determine what is most appropriate in the interests of patients and the public.

The Code's first principle is that you must make the care of patients your first concern and safeguard their wellbeing. Although the unborn child may have rights, the mother's life takes precedence. Emergency actions may adversely affect the foetus, but failure to administer naloxone to the unconscious woman could result in her death. A compromise might be to modify the mother's treatment to lessen risk to the baby.

The PGD should include staff training and state clearly what to do if pregnancy is suspected. Suggest using single dose preparations as, in a crisis, there may be a tendency to give more than the recommended dose from a multidose syringe. Other actions include:

- read the Advisory Council on the Misuse of Drugs: Report on Drug Related Deaths
- check with the drug services for information on local initiatives to reduce DRDs
- consider providing leaflets on prevention of DRDs to methadone and needle/syringe programme clients.

Kay Roberts, MPhil, FRPharmS, is chairman, PharMAG. Mary Hepburn BSc, MD, MRCGP, FRCOG, is consultant obstetrician at Princess Royal Maternity, Glasgow.

The pharmacist should be satisfied that it is lawful and appropriate to operate a PGD in these circumstances. Helpful guidance for England can be found on the NHS PGD website (www.portal.nelm.nhs.uk/PGD/default.aspx; in Scotland www.nes.scot.nhs.uk/pgds) and from the MHRA. The English guidance suggests that PGDs may not be appropriate for care homes run by the independent or public sector.

As well as complying with legal and ethical requirements, the pharmacist should take notice of the Society's PGD resource pack. Finally, the pharmacist should make sure his indemnity insurance covers setting up the PGD, as standard indemnity insurance may not. If the PGD is badly drawn up, the pharmacist might have to face a personal injury claim or a criminal investigation.

Noel Wardle, a solicitor at Charles Russell LLP, specialising in pharmacy law.

G1a, G1b, G1e, G1h, G1i, G3a, C1a, C4e. See http://tinyurl.com/68ox7b

For further reading go to www.chemistand druggist.co.uk/ethicaldilemma

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement
www.wingfieldworks.co.uk/plea/index.html

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This course provides a timely opportunity for pharmacists to update their public health knowledge and skills in preparation for the development of new contractual services.

Alastair Buxton
Head of NHS Services, PSNC

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- Written by public health experts and practising pharmacists.
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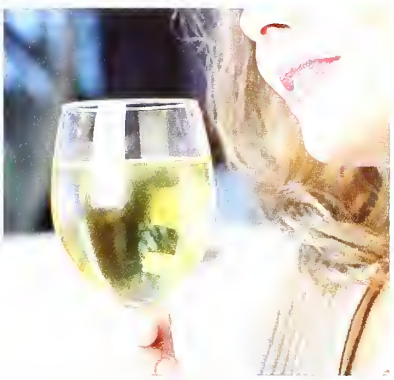
From C+D in association with Medway School of Pharmacy and PSNC, supported by an educational grant from GlaxoSmithKline.



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- **Behaviour change: Theory into Practice**
- **The Pharmacist as Public Health Practitioner**
- **Practical advice on running community pharmacy-based services to address:**
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  - **Cardiovascular disease (vascular risk assessment**

To find out more, please call **01732 377269**, email **pharmacytraining@cmpmedica.com** or go to **www.chemistanddruggist.co.uk/stafftraining**

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Taking care of baby

Pharmacy has seen its share of the babycare market being eroded by bigger retailers, so how can you tempt new parents back through your door? **James Clegg** reports

New parents are regular customers in the pharmacy. Looking for advice and accessible medicines, their trade supports a market for OTC children's medicines worth around £128 million as well as associated babycare products.

However, with more and more items in the sector, such as nappies, baby food and wipes, becoming the realm of supermarkets and other big retailers, what can pharmacy do to strengthen its bond with the babycare market?

Building and maintaining customer relationships is an obvious starting point. Pharmacists are often the first port of call for parents looking to ease their concerns about how junior is doing. The value of this is recognised by the major players.

Lloydspharmacy, for instance, says babycare is a growing category. Karl Baggott, who is responsible for babycare at the multiple, says: "It's an important area because expectant parents will often visit the pharmacy and will continue to visit during the first six months after birth to address any general concerns they have about their child's general health and wellbeing. By offering both products and healthcare advice at this important stage we underline the role that the pharmacist has to play at the heart of community healthcare."

Neil Wilson, Numark's trade marketing director, reinforces the point that the relationship starts before the birth and provides an opportunity to offer mums-to-be a wider range of healthcare services.

He says: "Pregnancy is an important time to build a relationship with a customer because it throws up issues where patients need reassurance. Talk to prospective mums about having their blood pressure checked and perhaps glucose checks for diabetes. You don't see the grocers doing that often, do you?"

The value of pharmacy's expertise is also recognised by manufacturers. Nutricia has a 47 per cent share of the baby food market as owner of the Aptamil range of milks, and market-dominating Cow & Gate.

Sales controller Mark Kennedy says: "An element that pharmacy can do, which is much harder for traditional retailers, is baby feeding advice. That advice can only be given by healthcare professionals so, in retail terms, pharmacists can own that."

Mr Kennedy is keen to maintain the link with the pharmacy sector but notes that "more and more of our business is moving towards grocery retail".

But what is the scale of that migration? According to market research company IRI, multiple stores hold around 88 per cent of the babycare market while pharmacies make up slightly less than 5 per cent. However, this may be a slightly distorted view as its "multiples" category includes Boots and Superdrug, as well as major supermarket grocery chains.

Nutricia's data also groups Boots in with mainstream retailers, so may give a gloomier view of how the baby market is crawling away.

A more optimistic picture is given by market research firm Euromonitor, which gives pharmacy a 36.7 per cent share of the market, putting it slightly ahead of grocers as the biggest supply channel for the sector. It is, however, worth noting that different companies base their figures on slightly different product categories in terms of what constitutes "babycare".

Russell Jones, senior insight manager at IRI, says the major trend in the sector has been a movement to supermarkets and other multiple retailers over the last 10 years, largely driven by big stores developing own-brand wipes.

Data from the company shows that wipes are currently the biggest part of the non-medical babycare market, accounting for £187.8m. Own label occupies nearly 40 per cent of this market, with the remainder largely shared by just three major companies: Johnson & Johnson (23.5 per cent), Pampers brand owner Procter & Gamble (22.5 per cent), and Kimberly-Clark, which owns Huggies (9.7 per cent).

According to Mr Jones: "The only way to fight back against own brand is to market very strongly. That's being done through in-store promotion and by offering multi-packs. Huggies and Pampers have been doing that and their market share is growing again."

So, while supermarkets and other big retailers are gaining an increasing share in the market through own-brand products, brands such as Pampers and Huggies continue to invest in marketing.

Nutricia, for example, has spent £9m on advertising the Aptamil and Cow & Gate brands this year, as well as providing point of sale marketing tools such as shelf markers. Other products with widespread media campaigns include Bepanthen, the fastest growing product in the nappy rash market (see p23 for details), which is running an eight-month digital campaign across parenting websites.

With these well-promoted brands in the pharmacy, new parents are bound to cross your doorstep sooner or later, so how can you make sure you put the two together?

Mr Kennedy of Nutricia says: "I think there is a fundamental basic that has to be got right which is less to do with promotion and more to do with retail and space management. It's ensuring that you cover the right ranges in the right space and that you have the market-leading brands available."

Rob Jackson, shopper-based design manager for pharmacy at nappies and wipes manufacturer Procter & Gamble, agrees. The company has been running a Pharmacy Care programme over the last 12 months, making sure that independents and small pharmacy chains are laying out babycare sections as effectively as possible. It currently covers about 500 stores.

Healthy start

For pharmacists in deprived areas, opting into the Healthy Start scheme could increase trade with parents on low incomes. Healthy Start is a Department of Health initiative to help pregnant women and children under four in low-income families to eat healthily by providing them with vouchers that are redeemable against food products, including formula milk. If you opt in as a Healthy Start retailer you get a sticker to put in the shop window that could increase footfall into your pharmacy. For more information go to www.healthystart.nhs.uk

> "INDEPENDENTS SHOULD BE CLEARING OUT THE BRANDS THAT AREN'T CLEARING AND MAKING SURE THEY HAVE A SMALL RANGE OF THE TOP BRANDS TO CHOOSE FROM"

Mr Jackson says: "We'll look at the space and say, let's define the categories so you have the right products there. Independents should be clearing out the smaller brands that aren't clearing and making sure they have a small range of the top brands to choose from."

The streamlining approach is one that Raj Patel of Mount Elgon Pharmacy in Wimbledon has had to take. Previously he had been selling reusable eco-friendly nappies but recently demand has fallen off. "I think the market has changed and we have had to adapt our model and get back to what people want," says Mr Patel, "It depends on the mums, and what they seem to want at the moment is Huggies and Pampers."

On the other hand, Roger Humbles of Fourway Pharmacy in Herne Hill, an Avicenna member, sees value in going for more obscure, eco-friendly products. "Margins are certainly better on biodegradable nappies, especially as the supermarkets sell Pampers and Huggies below my trade price."

Fourway Pharmacy has found babycare to be its biggest sales category, something that Mr Humbles puts down to being in a "middle-class, young family orientated area".

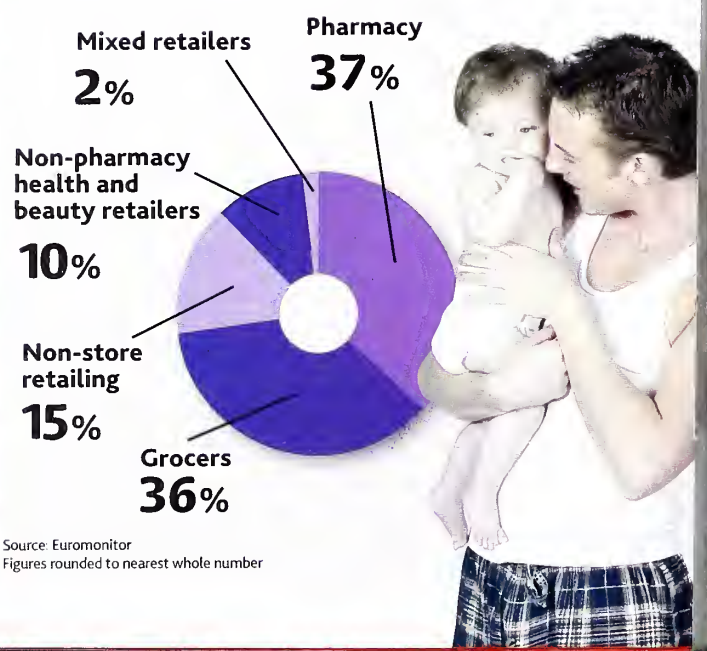
He said: "Toiletries do well and mainly we do green and organic brands, which are luxury items. If they can afford to, parents love to spoil their little ones."

This is borne out by market research from both Euromonitor and IRI that shows, outside of simple products like wipes, when the volume market for babycare starts to decline the value side stays steady because parents will buy premium products for their children.

A lot of the success of babycare ranges will depend on the pharmacy's locale and that will vary greatly. But one thing remains constant and that is the ability to be accessible and welcoming.

Mr Humbles says of his pharmacy: "Being local, small and friendly are our greatest assets. We get to know families and see them progress through different stages of life."

Distribution of babycare market in 2008



Source: Euromonitor
Figures rounded to nearest whole number

Bepanthen boosted by ad campaign

Nappy rash ointment Bepanthen is celebrating an upsurge in sales on the back of a sustained media campaign.

The brand claims that revenues have increased by up to 90 per cent following an "unprecedented" investment in promotion across television and the internet.

Bepanthen said the campaign, which focuses on the claim that the product "protects and cares from the causes of nappy rash", has triggered a rise in brand awareness from 17 per cent to 56 per cent.

According to data from market analyst IRI, it is also the fastest growing product in the nappy rash sector (IRI All outlets value share of market, MAT May 16, 2009).

Price: £6.25/100g; £3.22/30g
Ceuta Healthcare; tel: 01202 702558

Aptamil Pepti tempts with trial size

Aptamil Pepti, the prescription-only infant formula for cows' milk protein allergy, has launched a trial size pack.

The smaller 400g tin costs £8.62, which is equivalent pro rata to the existing larger 900g pack, which is priced at £19.39.

Aptamil Pepti was unveiled as the new name for Cow & Gate Pepti by the brand's parent company, Nutricia, in June. The change only affects the product's packaging – the hydrolysed whey-based formula, which contains prebiotic oligosaccharides, remains the same.

Nutricia said it decided to rebrand to reinforce the focus of Aptamil on immunity while Cow & Gate concentrates on its pre-term portfolio.

Price: £8.62/400g trial pack, 346-5689; 19.39/900g EaZypacks, 346-5671
Nutricia; tel: 08457 623676

Packaging change for Nutriprem

Cow & Gate Nutriprem has been repackaged with new labels that are designed to be easier to understand.

The labels explain how the product helps bottlefed preterm babies, both in the hospital and at home.

Formulations have not changed, and Cow & Gate Nutriprem is available in both liquid and powder forms.

The product is designed to give complete care and nutrition to bottlefed preterm and low birthweight babies up to six months corrected age. The manufacturer says it helps support babies' natural immune systems and healthy digestion.

Price: £14.02/900g, £2.32/200ml
Nutricia; tel: 08457 623624

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On the record

Not quite up to speed on CPD recording? Don't panic yet, says RPSGB CPD manager **Priya Rasanayagam**

From next week, you could be called on by the RPSGB to submit your CPD record. Haven't got one? Don't panic. Follow this guide to getting started.

Q Why do I need to make a CPD record?

A Mandatory CPD standards came into force in March that require all practising pharmacists and pharmacy technicians to keep their CPD records either electronically or on paper, and in a format published or approved by the RPSGB and carrying the Society's CPD logo. You can log onto the Society's CPD website to keep your record online (www.uptodate.org.uk) or, by installing the plan and record system, keep your record on your PC. You can also use the Society's plan and record paper record sheets.

The CPD standards require you to make a minimum of nine entries in a 12-month period. You must record how your CPD contributes to the quality or development of your practice and you must submit your CPD record to the Society when you are asked to do so – call and review.

Q I have had no time to start CPD – how can I prepare for call and review?

A Even if you think you have not undertaken CPD, you will no doubt have taken part in a wide range of learning activities during your career. You could have done this through practice-based learning, reviewing SOPs, conducting quality assessments and audits, reviewing critical incidents, or discussing work with your managers, colleagues, patients and other professionals.

Pharmacists and pharmacy technicians regularly set their own agenda, when it comes to learning,

CPD records can be stored online on the RPSGB's CPD website

such as by reading, writing reports, taking part in research, and giving lectures and presentations. All of these could form CPD entries. You may have also undertaken formal learning through continuing education by attending short courses, taking part in e-learning and studying for higher qualifications.

Q How do I record my CPD?

A The Society's plan and record system leads you through the four points of the cycle – reflection, planning, action and evaluation – with simple prompts. The system was relaunched earlier this month to make it more user-friendly.

While you can start the CPD cycle at any point in the process, CPD good practice advises you reflect on your practice at least once a month and to make some entries starting at reflection. If you don't know where to start the CPD cycle, the online plan and record system has a tool – Wizard – which appears when you select a new entry. Wizard takes you through a series of questions to identify the best starting point.

- **Reflection** means thinking about your learning needs and identifying your learning objectives. This may be done through your staff appraisals, personal development planning process, local audits, peer reviews or feedback you receive from other users such as patients or clients.

You may wish to use the personal development plan template provided in the recording systems to document your reflections. When making an entry you must clearly describe what you want to learn.

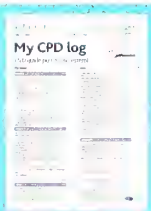
- **Planning** helps you decide how you intend to meet the learning identified during reflection. This could be by undertaking specific study programmes, web-based learning, through case studies, discussions with peers and by undertaking research. You will need to decide which form of learning will best help you achieve what you want to learn.
- **Action** means it's time to implement the learning you have identified and planned. Don't worry if you find yourself in a learning situation without any prior reflection or planning – in these cases, you can start your CPD entry at action.
- **Evaluation** comes at the end of the learning cycle when you assess whether or not you have achieved your learning objectives. You may find you didn't learn what you hoped to and need additional time.

If this happens, you can re-visit the learning to make a new entry and complete your CPD cycle. But if if you have fully or partly completed your learning, you'll have the opportunity to relate this learning to your practice and development.

If you have partially met your learning requirements, you would need to think about what you still need to do and what your next steps will be. You can then continue through the CPD cycle to meet these requirements.

CPD made easy

As part of C+D's weekly Update articles, you can now get an RPSGB-approved CPD log sheet, which helps you record your learning and development in a few simple steps. Further details of how you can get the CPD log sheet, pictured right, can be found on p18 (see '5 Minute Test') or phone 0 7-52 371369 for details.



Your questions answered

Where can I get help and information on CPD?

- The RPSGB's CPD website (www.uptodate.org.uk) provides CPD materials, case studies and answers to FAQs. There are four case studies specifically for community pharmacists on asthma treatment, medication reviews, Cox-2 inhibitors and the less clinical change management.
- On the Society's main website you can access the CPD standards, answers to FAQs on call and review and a five-minute guide to CPD (www.rpsgb.org.uk/registrationand support/continuingprofessional development).
- The Society will provide CPD facilitators free of charge to run support sessions on CPD for groups of 12 or more members. The course will be tailored to the needs of the group and adapted to cover different levels of experience as required, and can be provided at evenings or weekends. To request a facilitator fill in a form at www.rpsgb.org.uk/pdfs/cpdfacrequform.pdf), email cpdfacilitation@rpsgb.org or phone 020 7572 2602.
- If you need further information from the RPSGB contact the CPD helpdesk on 020 7572 2540 or email cpd@rpsgb.org. For technical queries, email helpdesk@coacs.com or telephone 01225 383663.

Other sources of CPD learning:

- The Centre for Pharmacy Postgraduate Education (CPPE) Workshops, open learning, e-learning and e-assessments, linked directly to the CPD cycle **www.cppe.ac.uk**
- NHS Education for Scotland (NES) Holding CPD surgeries on Thursday afternoons from next week (July 30) until mid-September **www.nes.scot.nhs.uk/pharmacy/cpd**
- Welsh Centre for Professional Pharmacy Education (WCPPE), CPD journal clubs and training sessions **www.wcppe.org.uk**

Advertisement Feature

Rebranding our stores. Developing our people.

More than 500 'your local Boots pharmacy' stores have now been rebranded. Regular readers will be aware of this and have seen the hugely positive impact that the rebrand has had on the pharmacists and teams within our stores. Now we thought we'd look at the rebrand from an organisational perspective and how the rebrand has affected Boots more widely.

We caught up with Joanne Hulme, Boots People Engagement Manager who's been central to this amazing achievement, working with the people impacted by the rebrand and ensuring what is delivered is as good as it possibly can be for colleagues and their customers.

Obviously she's delighted to have completed over 500 rebrands, "I have to say it is a fantastic achievement, and alongside it, we have also just completed another milestone for Boots, the 2000th Boots branded store, so it's actually a double celebration!"

More opportunities

The rebrand meant more than new look stores; they also continued Boots' tradition of providing its teams with excellent training and development opportunities. Our conversion to one operating platform means that our colleagues have the opportunity to experience a variety of different pharmacies and develop the career that's right for them.

Retail and dispensing colleagues have successfully trained as team and store managers in many cases, allowing Pharmacists to focus on patient care. Pharmacist managers have also benefited from the rebrand both in terms of the experience of leading their teams through a major change program but also from the fantastic new pharmacies which they now manage.

Bigger. Brighter. Better.

"Obviously the first thing people notice is the change to 'your local Boots pharmacy' but the wider reaction has also been very positive. Everyone loves having superb working environments, improved consulting rooms and sought after new retail ranges. One store manager commented to me that his rebranded store was exactly the reason he went into pharmacy – to be able to deliver professional healthcare in a community location."

What about the customers, how did they feel? "One of the greatest things I've learnt is just how crucial our store teams are to customers, and their communities. One customer said 'I love the new store, but I would have boycotted it if you had changed the staff'. This has formed a key pillar of the rebrand process, and all elements have been reviewed to be truly customer-led."

Isle love my new store

During our conversation Joanne talked about a store manager and pharmacist team on the Isle of Wight who were a great example of what the rebrand meant to them on a practical level. "Caroline the store manager told me that her store is more efficient now. That people like the new consultation room and appreciate the privacy and professionalism it provides. She also told me that the rebrand has had a positive affect on staff who feel more motivated. Her pharmacy team agree and complimented the beautiful layout, the bigger dispensary, and the ability to provide more services.

They even told me anecdotally that a customer commented that we were very big for a small pharmacy. That really sums up how successful the rebrand has been for everyone."

If you'd like to find out more, please visit **www.boots.jobs/localboots**

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TAX ADVICE FOR PHARMACIES

150 years of innovation

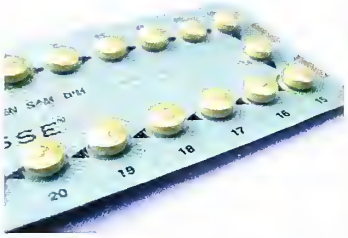
C+D 150

Seven weeks to go

As we countdown to C+D's 150th birthday on September 15, we are looking for the greatest innovation to emerge in pharmacy. We've cut the list down to eight and now we need you to vote for your favourite. The top four will face off in a live debate to decide the winner. Cast your vote today

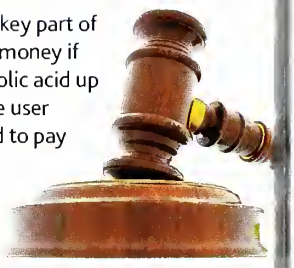
1 The contraceptive pill

The contraceptive pill has revolutionised birth control. While condoms were around long before, biologist Gregory Pincus put the power to prevent conception in the hands of women with its launch in 1960.



2 The carbolic smoke ball case

The Carbolic Smoke Ball case is a key part of UK contract law. After promising money if the device (a pump to squirt carbolic acid up the user's nose) didn't prevent the user catching flu, the company refused to pay out. The device's makers lost the case, making ridiculous advertisements a thing of the past. In theory, at least...



3 Penicillin

Antibiotics are some of the most important drugs in the pharmacy toolkit, and penicillin was the first to emerge. Its discoverer, the ever-modest doctor Alexander Fleming, probably summed it up best when he said: "I certainly didn't plan to revolutionise all medicine... but I guess that was exactly what I did."

4 Coca-Cola

Since its invention by pharmacist John Pemberton in 1886 to treat nausea and stomach upsets, the carbonated soft drink has gone from strength to strength. Coca-Cola currently holds Guinness World Records for the Largest Global Brand, Most Popular Soft Drink and, bizarrely, organising the World's Largest Line Dance.

5 Custard powder

When Mrs Bird complained she couldn't tolerate desserts containing eggs or yeast, her husband decided to do something about it. Always one with a sweet tooth, Birmingham pharmacist Alfred Bird created eggless custard and the result, Bird's Custard, is still on sale today.

6 The electric light bulb

Nothing is more synonymous with invention than a little light bulb appearing over someone's head – and it's only there because of pharmacy. UK druggist Sir Joseph Swan patented the light bulb in 1878, making his home in Gateshead the first to be lit by electricity.

7 Table salt

Before George Duncan Bowie, salt used to come in damp blocks. But in 1891 the Scottish pharmacist came up with phosphorated salt, preventing water absorption. Fellow pharmacist George Weddell took the idea and ran with it, tinkering to produce the free-flowing dry salt that graces fish and chip shop counters today.

8 NRT

In 1967 Swedish submarine crews were fed up of not being allowed to smoke. The Swedish government approached big pharma, and the result was nicotine gum to ease cravings. Now NRT has a key role in helping patients quit smoking, drastically improving health and lifestyles.

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Infant Colic - Management options using Lactase Enzyme

Following research[0] [1] at Guy's Hospital, which identified transient lactase deficiency as one possible causative factor in Colic, Colief Infant Drops are increasingly being recommended as a management option.

The research shows that transient lactase deficiency in the upper digestive tract may be corrected by adding lactase enzyme to the infant's feed before the baby is fed. Treatment protocols based on managing lactose in the baby's feed are now recognised as a primary treatment option for Infant Colic[2] [3].

This management strategy can be applied equally to breast-fed and formula-fed infants: in formula-fed babies by pre-incubating the formula with Colief (lactase enzyme), and with breast-fed babies by adding lactase to a little expressed breast milk (10 – 15ml) and feeding this to the baby immediately before breast-feeding.

[0] Kanabar et al, Journ Hum Nutr Dietet 2001.
[1] Review at www.jr2.ox.ac.uk/bandolier/booth/family/colicup.html
[2] NHS-Prodigy Clinical Guidance www.cks.library.nhs.uk/colic_infantile
[3] Marks et al, Guidelines Working Party Report www.eguidelines.co.uk/links/guidelines/summaries/gastrointestinal/wp_infant_colic.php

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